The "Jet Lag" Syndrome

"JET LAG" OR "TRAVELERS BLUES" is the result of transmeridian flight. Rapidly crossing several time zones results in internal biorhythms being in conflict with external cues and leads to a desynchronosis syndrome. The major signs and symptoms of desynchronosis are, in order of decreasing frequency:

- Fatigue and psychomotor degradation;
- Insomnia, sleep/wake disturbances;
- Anxiety or depression;
- Gastrointestinal dysfunction and
- Other psychophysiological complaints.

The intensity of these signs and symptoms is a function of many factors including the age and experience of the traveler, the total time shift, the number of stopovers and—to some extent—the direction of travel within the United States. West to east travel tends to be more desynchronizing because of departure and arrival times.

In studying various circadian rhythms, we note both external desynchronosis (inside time versus outside time) and internal desynchronosis (with two rhythms being out of synchronosis with each other) associated with temporal translocations of three hours or more.

While the somatic changes may be annoying they are less critical than the performance and psychological changes. There may appear significant decrements in complex and fine perceptual-motor behaviors. The individual person can be expected to have some increase in errors in these behaviors and these errors in some professions and occupations may be clinically or professionally relevant—as with professional musicians, race drivers or surgeons.

The second consistent change has to do with altered moods. In recent work we note significant increases in depression, hostility and aggression. The nature of one's task may be such that increased moodiness, irritability and tendencies to express anger are of no relevance. Again, however, some occupations and professions can ill afford any such impairment in behavior—for instance, those involved with contract negotiations or diplomacy.

Awareness of these changes allows for prevention or reduction of untoward effects. Certain suggestions for the traveler may help to reduce jet lag symptoms:

- For short stays it is best to stay on "home" time;
- When traveling west to east go to bed progressively earlier before the trip (vice versa east to west);
- For important meetings leave several days earlier (our findings indicate that 48 hours are needed for resynchronosis);
- Arrange important activities at *your* normal peak times—meet your European colleagues in late afternoon or evening;
- Use food and alcohol sparingly during the flight and the first three days after arrival—alcohol (and most tranquilizers and hypnotics) interferes with rapid eye movement (REM) sleep;
- On long transmeridian flights arrange a halfway stopover;
- Arrange your schedule to shorten the day rather than the night;
- Rest and relax for two days before working.

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Suicide in Physicians

PHYSICIANS WHO KILL THEMSELVES present particular personal and professional tragedies. From 150 to 200 physicians annually are lost to this preventable problem. The pain and stigma are immense.

The following factors are among those responsible for physician suicide.

Selection: Persons with an obsessive-compulsive style of life are often selected by medical schools. Despite the productive advantages of such a style of life, it does carry with it a proneness to depression in midlife and an attendant risk of suicide.

Training: During training, encouragement to deny feelings and symptoms in students—for seemingly sound traditional reasons but with tragic outcomes—occurs. In addition, patients encourage a growing sense of omnipotence in students during training. Both of these factors result subsequently in a denial of physical and psychic pain

in physicians and reluctance to seek help for personal pain.

Professional Life: The demands of patient care —with its immense responsibility and grinding endless work with frequent failure—may lead to emotional bankruptcy, depression and ultimately to suicide if alternative rewards are not fostered.

What are the danger periods? These are unusual in physicians, in that the highest risk period is the peak of professional life—age 35 to 54 years. Secondary risk periods are similar to those in the general population: following the loss of a spouse to death or divorce, during training years, and anticipating or following retirement.

Ambitious, driven physicians who over-extend themselves and suffer from chronic pain are at risk. Such people tend to drink too much or misuse drugs or have troubled marriages.

One should be aware of losses that colleagues are experiencing and look for depression in the year following a significant loss. Three to nine months after the loss is the period of highest risk. Any significant change in life style may signal a risk period. Subtle cues of depression and pseudohumorous comments made about death and suicide should be taken seriously. Relatively gentle probing may elicit suicidal ideation in a physician who is ambivalent about suicide. A denial of one's own pain or that of a colleague is life endangering. Signs and symptoms of alcohol or drug abuse need confronting immediately since delay benefits no one.

Treatment

The major problem in treatment is the hesitancy in recognizing the problem. As a group, physicians are great deniers of problems in themselves and, by extension, in colleagues. A secondary problem is that as a group, physicians are poorly educated about suicide generally and hence less able to deal rationally with the risk. The secondary problem is slowly resolving as physicians began to recognize that depression and drug problems are quite treatable and, in physicians particularly, have a good prognosis. The problem of denial is more difficult. It requires a colleague who sees the danger signals to intervene. There is no alternative but to take the risk of angry rejection. Someone must do this. In some medical societies the past presidents individually or as a committee have served to help troubled physicians on referral from other members of the society and with psychiatric consultation. This may be a workable alternative that meets the needs of all. Opening a person-to-person channel of communication with the suicidal physician is literally the lifeline of treatment. Definitive treatment of the underlying depression, drug problem, marital problem, or the like, cannot take place until someone reaches out. To not take the risk of reaching out means risking another's life.

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